

CHADIS

CHILD HEALTH & DEVELOPMENT INTERACTIVE SYSTEM



New Office Request Form

Date ____ / ____ / ____

Official Organization/office name: _____

Office Name for System Use: _____

(Please select a name that is recognizable by your parents)

Type of organization/practice (Check all that apply):

Pediatric DBP School Psychology Psychiatry Social Work Other _____

Number of clinicians: _____

Which CHADIS user will have responsibility for choosing the questionnaires that will be automatically assigned to patients based on their age and type of visit? _____

PRIMARY CONTACT INFORMATION (Type or Print Clearly)

Name _____

Email address _____

Street address _____

City _____ State _____

Zip code _____

Primary Phone () _____ ext. _____

Secondary Phone () _____ ext. _____

Fax _____